Braverman Eye/Laser Vision Correction Center

Post Operative Co- management Care

Date: ____________

Name of the Patient: _________________________

I understand that I will be returning to Dr. ____________________ for my post-operative care. For any unforeseen emergencies Dr. Braverman will still be available for my care. I authorize the doctors to share with one another information relating to my eye health, my vision or the post-surgical follow-up that they deem relevant for providing me with appropriate care.

Patient Signature: ________________________________

Witness Signature: _______________________________

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